Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: WALLS REGIONAL HOSPITAL 3255 W PIONEER PKWY ARLINGTON TX 76013	MFDR Tracking #: M4-08-6672-01
Respondent Name and Box #: JOHNS MANVILLE Rep Box # 17	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement from *Table of Disputed Services:* "Trauma DX Admit."

Principal Documentation:

1. DWC 60 Package
2. Total Amount Sought - $1336.00
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Coventry's Clinical Validation Department has reconsidered the above mentioned dates of service and have determined that the original review was accurate. Charges for the facility in which the provider elected to have procedures or surgery performed on an outpatient basis are paid at a fair and reasonable amount pursuant to the criteria set forth in Section 413.011(b) of the Texas Workers Compensation Act. In light of the reduced expensed incurred in an outpatient setting, it is unreasonable to pay more for an outpatient procedure or surgery than an inpatient surgery. The established per diem rate for an inpatient surgical day is set at $1,118.00. The per diem rate for a non-surgical inpatient medical stay is set at $870.00." … "Using these two rates as anchor points, reimbursement is determined based on the amount of time spent in the operating room Coventry has determined that the provider was not due additional money. It has determined that Coventry will stand on our original recommendation of $900.00."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
07/02/2007	150, 850-295, 900-083, W1, 647-002, 18, 999, 850-243, 900-030, 900-068	Outpatient Surgery	$1336.00	$0.00
Total /Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.

- 850-295-ABR ESIS: The recommended payment above reflect a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria set forth in Section 413.011(D) of the Texas Workers' Compensation Act.
- 900-083-ABR ESIS: This bill was reviewed through the advanced bill review program.
- W1-Workers Compensation State Fee Schedule Adjustment.
- 647-002-Reimbursement has been calculated based on a percentage of the charges.
- 18-Duplicate claim/service.
- 999-$6,727.10 of the charges are duplicates of bill #88888946-U-438002-0. Coventry originally reviewed this bill on 07/27/2007 and recommended a total allowance of $900.00.
- 850-243-CV: The recommended allowance reflects a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria set forth in Section 413.011(D) of the Texas Workers' Compensation Act. M-No MAR $0.00. M-No MAR $900.00.
- 900-030-CV: This charge was reviewed through the clinical validation program.
- 900-068-CV: Additional reconsideration of this bill and submitted documentation does not support additional payment. Recommended final allowance.

2. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.

3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC§134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67on the hospital bill finds that the principle diagnosis code is listed as 836.2.The Division therefore determines that this inpatient admission is a trauma admission and shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).

4. This dispute relates to outpatient surgery services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

6. Division rule at 28 TAC §133.307(c)(2)(A), effective May 25, 2008, and applicable to disputes filed on or after May 25, 2008, 31 TexReg 3954, requires that the request shall include "a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills)." This request for medical fee dispute resolution was received by the Division on July 1, 2008. Review of the submitted documentation finds that the requestor did not submit a reconsideration bill. Therefore, the requestor has failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(A).

7. Division rule at 28 TAC §133.307(c)(2)(F)(i), effective May 25, 2008, and applicable to disputes filed on or after May 25, 2008, 31 TexReg 3954 requires that the request shall include a position statement of the disputed issues(s) that shall include: (i) a description of the health care for which payment is in dispute." A review of the submitted documentation finds that the requestor did not submit a position statement that included a description of the health care for which payment is in dispute. Therefore, the requestor has failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(F)(i).

8. Division rule at 28 TAC §133.307(c)(2)(F)(ii), effective May 25, 2008, and applicable to disputes filed on or after May 25, 2008, 31 TexReg 3954 requires that the request shall include a position statement of the disputed issues(s) that shall include: (ii) the requestor's reasoning for why the disputed fees should be paid or refunded." A review of the submitted documentation finds that the requestor did not submit a position statement that included a reasoning for why the disputed fees should be paid or refunded. Therefore, the requestor has failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(F)(ii).

9. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective May 25, 2008, and applicable to disputes filed on or after May 25, 2008, 31 TexReg 3954 requires that the request shall include "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues."… Review of the requestor's position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iii).

10. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective May 25, 2008, and applicable to disputes filed on or after May 25, 2008, 31 TexReg 3954 requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iv).

11. Division Rule at 28 TAC §133.307(c)(2)(G), effective May 25, 2008, 33 TexReg 3954, and applicable to disputes filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable". The requestor did not submit a position statement for consideration in this dispute. Review of the submitted documentation finds that the requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated. The requestor's rationale for increased reimbursement from the Table of Disputed Services states "Trauma DX admit." However, the requestor does not further discuss or explain how the amount in dispute was calculated or arrived at. The provider's Request for Reconsideration cover letter states "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the APC rate of $1759.49 for APC number 041. Allowing this at 140% would yield a fair and reasonable allowance of $2463.29. Based on your payment of $900.00, a supplement payment is still due of $1563.29"; however, the payment calculation and amount requested in the Request for Reconsideration cover letter does not match the amount in dispute from the requestor's Table of Disputed Services. Additionally, the requestor did not provide documentation, such as Medicare fee schedules, redacted EOBs, payment policy manual excerpts, or other evidence, to support the Medicare payment calculation. The requestor does not explain how it determined that payment of the amount in dispute would result in a fair and reasonable reimbursement for the disputed services. The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the statutory requirements and Division rules. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the requested reimbursement amount. Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement. The request for additional reimbursement is not supported. Additional reimbursement cannot be recommended.

12. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(F)(i), §133.307(c)(2)(F)(ii), §133.307(c)(2)(F)(iii), §133.307(c)(2)(F)(iv), and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401, §133.250
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

12/11/2009

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.